DELTA DENTAL

PPO PLUS PREMIER NETWORK

PLAN DESCRIPTION EFFECTIVE
JANUARY 1, 2026

ARIZONA
DEPARTMENT OF ADMINISTRATION
BENEFITS SERVICES DIVISION

www.benefitoptions.az.gov

Table of Contents

ARTICLE 1 PLAN MODIFICATION, AMENDMENT AND TERMINATION 1

ARTICLE 2 ESTABLISHMENT OF PLAN 2

ARTICLE 3 ELIGIBILITY AND PARTICIPATION 3

ARTICLE 4 PREDETERMINATION 13

ARTICLE 5 PROVIDER NETWORK 14

ARTICLE 6 SCHEDULE OF DENTAL BENEFITS AND COVERED SERVICES 16

ARTICLE 7 EXCLUSIONS AND GENERAL LIMITATIONS 23

ARTICLE 8 COORDINATION OF BENEFITS AND OTHER SOURCES OF PAYMENT 26

ARTICLE 9 CLAIM FILING PROVISIONS AND APPEALS PROCESS 29

ARTICLE 10 ADMINISTRATION 34

ARTICLE 11 LEGAL NOTICES 36

ARTICLE 12 MISCELLANEOUS 39

ARTICLE 13 PLAN IDENTIFICATION 40

ARTICLE 14 DEFINITIONS 41

ARTICLE 1

PLAN MODIFICATION, AMENDMENT AND TERMINATION

The Plan Sponsor reserves the right to, at any time, amend, change or terminate benefits under the Plan; to amend, change or terminate the eligibility of classes of employees to be covered by the Plan; to amend, change, or eliminate any other Plan term or condition; and to terminate the whole Plan or any part of it. When a change or amendment happens, a Summary of Material Modification (SMM) will be attached to this Summary Plan Description (SPD).

No consent of any Member is required to terminate, modify, amend or change the Plan.

Termination of the Plan will have no adverse effect on any benefits to be paid under the Plan for any covered medical expenses incurred prior to the termination date of the Plan.

This Plan document is effective January 1, 2026 and supersedes all Plan Descriptions and all enrollment guides previously issued by the Plan Sponsor. When the law requires, you will receive notice of changes no later than 60 days prior to the effective date of the change.

ARTICLE 2

ESTABLISHMENT OF PLAN

2.1 Purpose

Pursuant to Arizona law, A.R.S. § 38-651, the Department of Administration established this Plan to provide for the payment or reimbursement of covered dental expenses incurred by eligible Plan Members.

2.2 Exclusive Benefit

This Plan is established and shall be maintained for the exclusive benefit of eligible Members.

2.3 Compliance

This Plan is established and shall be maintained with the intention of meeting the requirements of all pertinent laws. Should any part of this Plan Description, for any reason, be declared invalid, such decision shall not affect the validity of any remaining portion, which remaining portion shall remain in effect as if this Plan Description has been executed with the invalid portion thereof eliminated.

2.4 Legal Enforceability

The Plan Sponsor intends that terms of this Plan, including those relating to coverage and Benefits provided, are legally enforceable by the Members, subject to the enrollee's retention of rights to amend or terminate this Plan as provided elsewhere in this Plan Description.

2.5 Note to Members

This Plan Description describes the circumstances when this Plan pays for dental care. All decisions regarding dental care are up to a Member and the Dentist. There may be circumstances when a Member and the Dentist determine that dental care, which is not covered by this Plan, is appropriate. The Plan Sponsor and Delta Dental do not provide or ensure quality of care.

Delta Dental contracts with network dentists under this Plan. These dentists are affiliated with the Delta Dental Premier network and/or the Delta Dental PPO network and do not have a contract with the Plan Sponsor.

ARTICLE 3

ELIGIBILITY AND PARTICIPATION

3.1 Eligibility

The Plan is administered in accordance with Section 125 Regulations of the Internal Revenue Code and the Arizona Administrative Code.

Please see Article 14 for definitions of the terms used below.

Benefit Services will provide potential members reasonable notification of their eligibility to participate in the Plan as well as the terms of participation. Both Benefit Services and Delta Dental have the right to request information needed to determine an individual's eligibility for participation in the Plan.

3.2 Member Eligibility

Eligible employees, eligible retirees, and eligible former elected officials may participate in the Plan.

In certain situations, an individual may be eligible to enroll as both a member and a dependent. This individual should enroll either as a member or as a dependent but never both.

3.3 Dependent Eligibility

Member's legal spouse and eligible child(ren) until the age of 26 may participate in the Plan. An Eligible Dependent may not participate in the Plan unless an Eligible Employee, Eligible Retiree, or Eligible Former Elected Official is also enrolled.

In certain situations, an individual may be eligible to enroll as both a member and a dependent. This individual should enroll either as a member or as a dependent but never both.

In certain situations, an individual may be eligible to participate as a dependent of more than one member. This individual should be enrolled as the dependent of only one of the members.

3.4 Continuing Eligibility through COBRA

See Section 3.14 of this article.

3.5 Non-COBRA Continuing Eligibility

The following individuals are eligible for continuing coverage under the Plan.

Eligible Employee on Leave without Pay

An employee who is on leave without pay for a health-related reason that is not an industrial illness or injury may continue to participate in the Plan by paying both the state and employee contribution. Eligibility shall terminate on the earliest of the employee:

- Receiving long-term disability benefits that include the benefit of continued participation;
- Becoming eligible for Medicare coverage; or
- Completing 30 months of leave without pay.

An employee who is on leave without pay for other than a health-related reason may continue to participate in the Plan for a maximum of six months by paying both the state and employee contributions.

Surviving Dependent(s) of Covered Retiree
Upon the death of a retiree covered under the Plan, the surviving dependents are eligible to continue coverage under the Plan, provided each was covered at the time of the member's death, by payment of the retiree premium.

If the spouse survives, he/she, for purposes of Plan administration, will be reclassified as a member. As such, he/she may enroll dependents as allowed under Section 3.3. Coverage for the surviving spouse may be continued indefinitely provided the appropriate premium is paid.

In the case where children, who are eligible dependents of the surviving spouse, survive, they may continue participation in the Plan if enrolled by the surviving spouse as allowed under Section 3.3.

In the case where children survive but no spouse survives or the children are not eligible dependents of the spouse, each child, for purposes of Plan administration, will be reclassified as a member. As such, each child may enroll dependents as allowed under Section 3.3. In this circumstance, coverage for each surviving child may be continued indefinitely provided the appropriate premium is paid.

Please note that a dependent not enrolled at the time of the member's death may not enroll as a surviving dependent.

Surviving Spouse/Child of Covered Employee Eligible for Retirement under the Arizona State Retirement System (ASRS)
Upon the death of a covered employee meeting the criteria for retirement under the ASRS, the surviving spouse and children, provided each was enrolled at the time of the member's death, are eligible to continue participation in the Plan by payment of the retiree premium.

If the covered spouse survives, he/she, for purposes of Plan administration, will be reclassified as a member. As such, he/she may enroll dependents as allowed under Section 3.3. Coverage for the surviving spouse may be continued indefinitely provided the appropriate premium is paid.

In the case where covered children, who are eligible dependents of the surviving spouse, survive, they may continue participation in the Plan if enrolled by the surviving spouse as allowed under Section 3.3.

In the case where covered children survive but no spouse survives, each child, for purposes of Plan administration, will be reclassified as a member. As such, each child may enroll dependents as allowed under Section 2.3. In this circumstance, coverage for each surviving child may be continued indefinitely provided the appropriate premium is paid.

Please note that a child/spouse not enrolled as a dependent at the time of the member's death may not enroll as a surviving child/spouse.

Surviving Spouse of Elected Official or Covered Former Elected Official (EORP)
Upon the death of a former elected official covered under the Plan, the surviving spouse may continue participation in the Plan, provided that he/she was enrolled at the time of the member's death, by

payment of the retiree premium. The surviving spouse, for purposes of Plan administration, will be reclassified as a member. As such, he/she may enroll dependents as allowed under Section 3.3. Coverage for the surviving spouse may be continued indefinitely provided the appropriate premium is paid.

Please note that a spouse not enrolled at the time of the former elected official's death may not enroll as a surviving spouse.

Upon the death of an elected official who would have become eligible for coverage upon completion of his/her term, the surviving spouse may continue participation in the Plan, provided that he/she was enrolled at the time of the elected official's death, by payment of the retiree premium. The surviving spouse, for purposes of Plan administration, will be reclassified as a member. As such, he/she may enroll dependents as allowed under Section 2.3. Coverage for the surviving spouse may be continued indefinitely provided the appropriate premium is paid.

Please note that a spouse not enrolled at the time of the elected official's death may not enroll as a surviving spouse.

Surviving Spouse or Dependent of a Law Enforcement Officer Killed in the Line of Duty
Upon the death of an insured Employee meeting the criteria under A.R.S. § 38-1114, the Surviving Spouse and/or Dependent are eligible to participate in the Plan.

3.6 Eligibility Audit

Benefit Services may audit a member's documentation to determine whether an enrolled dependent is eligible according to the Plan requirements. This audit may occur either randomly or in response to uncertainty concerning dependent eligibility.

Both Benefit Services and Delta Dental have the right to request information needed to determine an individual's eligibility for participation in the Plan.

3.7 Grievances Related to Eligibility

Individuals may file a grievance with the Director of the Benefits Services Division regarding issues related to eligibility, including determinations of eligibility, coverage terminations, or rescissions. To file a grievance, the individual should submit a letter to the Director that contains the following information:

- Name and contact information of the individual filing the grievance;
- Nature of the grievance; and
- Nature of the resolution requested.
- Supporting Documentation

The Director will provide a written response to a grievance within 60 days.

3.8 Enrollment Procedures and Commencement of Coverage

New enrollments or coverage changes will only be processed in certain circumstances. Those circumstances are described below.

3.9 Initial Enrollment

Once eligible for coverage, potential members have 31 days to enroll and provide required documentation for themselves and their dependents in the Plan.

It should be emphasized that coverage begins only after an individual has successfully completed the enrollment process by submitting a completed election and providing any required documentation within 31 days. Benefits will be effective as referenced on the following table. Supporting documentation is required.

The table below lists pertinent information related to the initial enrollment process.

Category	Must enroll within 31 days	Enrollment contact	Coverage begins on the[1]
Eligible state employee	Date of hire	Agency Liaison	First day of first pay period after completion of enrollment process
Eligible university employee	Date of hire	Human Resources Office	First day of first pay period after completion of enrollment process
Eligible participating political subdivision employee	Date of hire	Human Resources Office	*Please contact the appropriate Human Resources Office*
Eligible retiree	Date of retirement	Benefit Services	First day of first month after completion of enrollment process[2]
Eligible former elected official	Date of leaving office or retiring	Benefit Services	First day of first month after completion of enrollment process[3]

3.10 Open Enrollment

Before the start of a new plan year, members are given a certain amount of time during which they may change coverage options. Potential members may also elect coverage at this time. This period is called open enrollment.

In general, open enrollment for eligible employees, retirees and former elected officials is held in October/November.

At the beginning of each year's open enrollment period, enrollment information is made available to those eligible for coverage under the Plan. This information provides details regarding changes in benefits as well as whether a current member is required to re-elect his/her coverage during open enrollment (called a "positive" open enrollment).

[1] Under no circumstance will coverage for a dependent become effective prior to the member's coverage becoming effective.

[2] For state employees entering retirement and their dependents, coverage begins the first day of the first pay period following the end of coverage as a state employee. This results in no lapse in coverage.

[3] Eligibility is subject to A.R.S. § 38-802.

Elections must be made before the end of open enrollment. Those elections – or the current elections, if no changes were made and it was not a positive open enrollment – will be in effect during the subsequent plan year.

Coverage for all groups begins on the first day of the new plan year. It should be emphasized that coverage options change only after an individual has successfully completed the enrollment process by submitting a completed election and providing any required documentation within 31 days of the end of the open enrollment period.

3.11 Qualified Life Event Enrollment

If a qualified life event occurs, members have 31 days to enroll or change coverage options.

Changes made as a result of a qualified life event must affect eligibility for coverage and must be consistent with the event itself.

It should be emphasized that coverage options change only after an individual has successfully completed the enrollment process by submitting a completed election and providing any required documentation within 31 days of the end of the qualifying event.

State employees should contact the appropriate agency liaison when they choose to change coverage options as a result of a qualified life event. University and political subdivision employees should contact the appropriate human resources office. Retirees and former elected officials should contact Benefit Services.

For state employees, most coverage changes become effective on the first day of the first pay period after completion of enrollment. For retirees and former elected officials, most coverage changes become effective on the first day of the first month after completion of the enrollment process. University and political subdivision employees should contact the appropriate human resources office for information regarding the effective date of coverage changes.

If you request a change due to a HIPAA special enrollment event within the 31-day timeframe, coverage for birth, adoption, or placement for adoption will become effective on the date of birth, adoption or placement for adoption. For all other HIPAA Special Enrollment events, coverage will become effective the first day of the next month following your request for enrollment.

A Surviving Spouse/Dependent must submit a completed election form and provide any required documentation within six months of the death of the insured Retiree or insured Employee eligible for retirement under the ASRS. A Surviving Spouse/Dependent of an Elected Official or Formal Elected Official has 31 days to complete the election form and provide required documentation.

The table below lists pertinent information related to the qualified life event enrollment process. It should be noted that not all qualified life events are listed below.

Type of event	Must enroll/change coverage within 31 days of	Coverage/change in coverage begins on the[4]
Marriage	Date of the event	The first day of the next month
Loss of other coverage due to: ● Divorce, annulment, or legal separation ● Change in dependent employment status ● Death of spouse	Date of the event	The first day of the next month
Employment status change (beginning employment, termination, strike, lockout, beginning/ ending FMLA, full-time to part-time)	Date of the event	The first day of the first pay period
Change in residence affecting coverage availability	Date of the event	The first day of the next month
Loss/gain of dependent eligibility (other than listed below)	Date of the event	The first day of the next month
Newborn[5]	Date of birth	Date of birth[6]
Adopted child	Date of placement for adoption	Date of adoption[7]
Child placed under legal guardianship	Date member granted legal guardianship	Date member granted legal guardianship[7]
Child placed in foster care	Date of placement in foster care	Date of placement in foster care

3.12 Change in Cost of Coverage

If the cost of benefits increases or decreases during a plan year, Benefit Services may, in accordance with plan terms, automatically change your elective contribution.

When the Benefit Services determines that a change in cost is significant, a member may elect less-costly coverage.

3.13 Termination of Coverage

Coverage for all members/dependents ends at 11:59 p.m. on the date the Plan is terminated. Failure to pay employee premiums could result in retroactive termination to the last day of the pay period which premium was paid through. The employee and their dependents will not be allowed to re-enroll until the following Open Enrollment period. Termination of coverage prior to that time is described in the table below.

[4] University and political subdivision employees should contact the appropriate human resources office for information regarding effective date of coverage changes.

[5] Born to member or member's legal spouse.

[6] Coverage ends on the 31st day after the date of birth if a member does not enroll a newborn in the Plan.

[7] A Child recently adopted, placed under legal guardianship, or placed in foster care covered from the date of adoption *only if a member* subsequently enrolls a child in the Plan.

Category	Coverage ends at 11:59 p.m. on the earliest of

Eligible state/university employee	• Last day of the pay period for/in which the member:
	  Makes last contribution;
	  Fails to meet the requirements for eligibility
	• Last day members are eligible for extension of coverage.

Eligible participating political subdivision employee	*Please contact the appropriate human resources office*

Eligible retiree[8]/former elected official	• Last day of the month for/in which the member:
	  Makes last premium payment; or
	  Fails to meet the requirements for eligibility.

Eligible long-term disability recipient	• Last day of the month in which the disability benefit ends.

Eligible dependent	• The last day of the month which the dependent child reaches the limiting age of 26;
	• Day the dependent:
	  Dies; or
	  Loses eligibility for reason other than limiting age;
	• Day the member:
	  Is relieved of a court-ordered obligation to furnish coverage for a dependent child; or
	  Is no longer covered.

Eligible employee on leave without pay	• Last day of period in which member becomes eligible for:
	  Long-term disability benefits for which there is eligibility to continue coverage under the plan; or
	  Coverage under Medicare; or
	• 30 months after the leave-without-pay period began.

Surviving child/spouse of eligible retiree	• Last day of the period for which the member makes last payment; or • Day the surviving child fails to be eligible as a child.
Surviving spouse of elected official or eligible former elected official	• Last day of the period for which the member makes the last payment.

3.14 Continuing Eligibility through COBRA

Eligibility of Enrolled Members/Dependents

In accordance with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), a member/dependent who has had a loss of coverage due to a qualifying event may extend his/her coverage under the Plan for a limited period of time. A member or dependent eligible for COBRA coverage is referred to as a "qualified beneficiary".

To be eligible for COBRA coverage as a qualified beneficiary, a member/dependent must be covered under the Plan on the day before the qualifying event. Each qualified beneficiary may elect COBRA coverage separately. For example, a dependent child may continue coverage even if the member does not.

[8] Excluding long-term disability recipient.

Members and dependents would be eligible for COBRA coverage in the event that the State of Arizona files bankruptcy under Title 11 of the U.S. Code.

The table below lists individuals who would be eligible for COBRA coverage if one of the corresponding qualifying events were to occur.

Category	Duration of COBRA coverage	Qualifying event
Eligible employee, dependent	Up to 18 months[9]	• Voluntary or involuntary termination of member's employment for any reason other than "gross misconduct"; or • Reduction in the number of hours worked by member (including retirement)[10].
Dependent	Up to 36 months	• Member dies; or • Member and dependent spouse divorce or legally separate; or
Dependent child	Up to 36 months	• Dependent child no longer meets eligibility requirements.

3.15 Subsequent Qualifying Events

An 18-month COBRA period may be extended to 36 months for a dependent if the:

- Member dies; or
- Member and dependent spouse divorce or legally separate; or
- Dependent child no longer meets eligibility requirements.

This clause applies only if the second qualifying event would have caused the dependent to lose coverage under the Plan had the first qualifying event not occurred.

3.16 Eligibility of Newly Acquired Eligible Dependents

If the qualified beneficiary gains an eligible dependent during COBRA coverage, the dependent may be enrolled in the Plan through COBRA. The qualified beneficiary should provide written notification to Benefit Services within 31 days of the qualifying life event. Newly acquired dependents may not be enrolled in the COBRA coverage after 31 days.

3.17 Special Rules Regarding Disability

The 18 months of COBRA coverage may be extended to 29 months if a qualified beneficiary is determined by the Social Security Administration to have a disability at the time of the first qualifying event or during the first 60 days of an 18-month COBRA coverage period. This extension is available to all family members who elected COBRA coverage after a qualifying event.

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[9] If the member and/or dependent has a disability when he/she becomes eligible for COBRA or within the first 60 days of COBRA coverage, duration of coverage may be extended to 29 months. See Section 3.17 for Special Rules Regarding Disability. Also, if an employee becomes entitled to Medicare benefits less than 18 months before his or her termination of employment or reduction in hours, COBRA coverage for the employee's covered dependents may last for up to 36 months from the date of the member's Medicare entitlement.

[10] If the member takes a leave of absence qualifying under the Family and Medical Leave Act (FMLA) and does not return to work, the COBRA qualifying event occurs on the date the member notifies ADOA that he/she will not return, or the last day of the FMLA leave period, whichever is earlier.

To receive this extension, the member must provide Benefit Services with documentation supporting the disability determination within 60 days after the latest of:

- The date of the Social Security Administration disability determination;
- The date of the qualifying event; or
- The date coverage is/would be lost because of the qualifying event.

3.18 Payment for COBRA Coverage

Qualified beneficiaries who extend coverage under the Plan due to a COBRA qualifying event must pay 102% of the total premium. Qualified beneficiaries whose coverage is extended from 18 months to 29 months due to disability may be required to pay up to 150% of the active premium beginning with the 19th month of COBRA coverage.

COBRA coverage does not begin until payment is made to the COBRA administrator. A participant has 45 days from submission of his/her election of COBRA to make the first payment. Failure to comply will result in loss of COBRA eligibility.

3.19 Notification by the Member/Dependent

COBRA coverage cannot be elected if proper notification is not made in a timely manner. Under the law, the Plan must receive written notification of a divorce, legal separation, dissolution of partnership, or child's loss of dependent status, within 60 days of the later of the:

- Date of the event; or
- Date coverage would be lost because of the event.

Notification must include information related to the member and/or dependent(s) requesting COBRA coverage. Documentation may be required.

Written notification should be directed to:

ADOA Human Resources Benefits
100 N. 15th Avenue, Suite 301
Phoenix, AZ 85007

3.20 Notification by the Plan

The Plan is obligated to notify each participant of his/her right to elect COBRA coverage when a qualifying event occurs and the Plan is notified in accordance with Section 3.19.

3.21 Electing COBRA Coverage

Information related to COBRA coverage and enrollment may be obtained through an agency liaison or by calling Benefit Services at 602-542-5008 or 1-800-304-3687 or by writing to the address provided in Article 13.

3.22 Early Termination of COBRA Coverage

The law provides that COBRA coverage may, for the reasons listed below, be terminated prior to the 18-, 29-, or 36-month period:

- The Plan is terminated and/or no longer provides coverage for eligible employees;
- The premium is not received within the required timeframe;
- The member enrolls in another group health plan; or
- The member becomes eligible for Medicare.

For members whose coverage was extended to 29 months due to disability, COBRA coverage will terminate after 18 months or when the Social Security Administration determines that the member no longer has a disability.

3.23 Contact Information for the COBRA Administrator

COBRA-related questions or notifications should be directed to Benefit Services.

ARTICLE 4

PREDETERMINATION

4.1 Predetermination or Pre-Estimate

During your first appointment, advise your dentist that you are covered by Delta Dental. Members and their Dependents should provide the dentist with the member identification number in order to receive services.

Pre-Determination is the pre-treatment estimate that can help protect the Member from unanticipated charges. If dental services over two hundred fifty dollars ($250) are needed, ask your dentist to complete a pre-determination of benefits and submit the form to Delta Dental. After an examination, your dentist will establish the treatment to be performed.

Delta Dental will verify your eligibility and determine the amount of benefits payable by your Plan. The pre-determination voucher will be returned by Delta Dental to the Participating Dentist with a copy to you. If you see a Non-participating Dentist, the pre-determination voucher will be returned by Delta Dental only to you. The amount of the allowable fee, the amount of benefits payable by the Plan and the portion you are required to pay will be shown on the voucher and should be discussed with the dentist before extensive treatment begins.

In order to be considered for coverage under this Plan, the date of service for the dental treatment estimated in the pre-determination Explanation of Benefits must occur before the termination of coverage and be completed within thirty (30) days after the termination of coverage.

Pre-determinations are only valid for the procedure and for the dentist who submitted the predetermination request and may not be transferred to any other dentist. All fee information is confidential. To estimate your out-of-pocket expenses, ask your dentist to submit a predetermination.

ARTICLE 5

PROVIDER NETWORK

5.1 Participating Dentist

On the date of service, if the dentist is a participating dentist (a dentist who has signed an agreement with Delta Dental Member Company):

1. The dental office will complete the claim forms and submit to Delta Dental for payment, predetermination or coordination of benefits.
2. The Member is required to pay only the co-insurance (if any) and/or deductible (if any) for covered benefits.
3. Participating Dentist reimbursement:
   - Payment to a dentist participating in the Delta Dental PPO network will not exceed the Table of Allowance for the state in which services are rendered.
   - Payment to a dentist exclusively participating in the Delta Dental Premier network will not exceed the Maximum Reimbursable Amount for the state in which services are rendered.

5.2 Non-Participating Dentist within the United States

On the date of service, if the dentist is a non-participating dentist (a dentist who has not signed an agreement with a Delta Dental Member Company, or who has terminated as a Participating Dentist):

1. The Member will be responsible for the submission of the claim form or the predetermination of benefits form to Delta Dental.
2. The Member will be responsible to the non-participating dentist for the full cost of treatment and Delta Dental will reimburse the non-participating dentist for the amount of benefits payable by the Plan. The Member may choose to assign a benefit payment to a non-participating dentist within the United States. The member will be responsible for obtaining any refund from the non-participating dentist.
3. The payment for the treatment will be based on the lesser of the billed charges or the Non-Participating Dentist Table of Allowance for the state in which services are rendered. You will be required to pay the difference between any amount billed by the dentist and that state's Non-Participating Dentist Table of Allowance. This payment results, in most instances, in a reduced benefit when compared to the benefit paid for the same service to a Participating Dentist.

5.3 Non-Participating Dentist outside the United States

On the date of service, if the dentist is a non-participating dentist (a dentist who has not signed an agreement with a Delta Dental Member Company, or who has terminated as a Participating Dentist):

1. The Member will be responsible for the submission of the claim form or the predetermination of benefits form to Delta Dental.
2. The claim form must include the billed charges in that country’s currency and a conversion fee into United States dollars.
3. The Member will be responsible for the submission of a copy of that dentist’s license to practice dentistry in the country services were rendered.

4. The Member will be responsible to the non-participating dentist for the full cost of treatment and Delta Dental will reimburse the Member for the amount of benefits payable by the Plan. The benefits in the Plan may not be assigned to an out-of-country nonparticipating dentist.
5. The payment for the treatment will be based on the lesser of the billed charges or Delta Dental's Foreign Non-Participating Dentist Table of Allowance. You will be required to pay the difference between any amount billed by the dentist and Delta Dental's Foreign Non-Participating Dentist Table of Allowance. These payments result, in most instances, in a reduced benefit when compared to the benefit paid for the same service to a Participating Dentist or Non-Participating Dentist within the United States.

ARTICLE 6

SCHEDULE OF DENTAL BENEFITS AND COVERED SERVICES

6.1 Schedule of Dental Benefits and Covered Services Chart

The chart below is intended to be a summary of the benefits and covered Services and does not include all limitations and/or exclusions. Pre-determination is recommended for services over $250. Please refer to Article 4 for details.

	Coverage	Limitations
Annual Benefit Maximum In-Network and Out of Network	$2,000	Benefit dollars used for Routine Services (Class I) services will not apply to the Annual Maximum.
Annual Deductible Single Employee & Adult Employee & Child Family	 $50 $100 $100 $150	
Routine Services (Class I) **No Deductible** **Services do not apply to annual benefit maximum**		
Exams, periodic or comprehensive	100%	Two per plan year
Problem Focused Exam, Evaluation or Consultation	100%	One per plan year
X-Ray Full Mouth, Panorex, Vertical Bitewings	100%	Once in a three-year period
X-Ray Bitewing	100%	One set per plan year
Periapicals	100%	As needed
Routine Prophylaxis (Cleaning)	100%	Two per plan year
Full Mouth Debridement	100%	Once in a five-year period. Will be exchanged for one routine cleaning.
Topical Application of Fluoride	100%	Up to the age of eighteen. Two per plan year.
Space Maintainers	100%	For missing posterior primary (baby) teeth. Up to the age of fourteen.
Basic Services (Class II) **Deductible applies to services** **Services apply to annual benefit maximum**		
Fillings Silver Amalgam Synthetic Tooth Color	80%	One surface every two years
Stainless Steel Crowns	80%	For primary baby teeth
Sealants – permanent Permanent Molars and Bicuspids	80%	Up to the age of nineteen every three years
Endodontics Root Canal (Permanent Teeth)	80%	Once per tooth per lifetime

Pulpotomy (Primary Baby Teeth)		
Endodontics Retreatment	80%	 Once in a three year period
Periodontics Non-surgical Surgical	80%	 Once every two years Once every three years
Oral Surgery Extractions	80%	None
Emergency Palliative Treatment	80%	None
Major Services (Class III) **Deductible applies to services** **Services apply to annual benefit maximum**		
Restorative Crowns Onlays	50%	Five year waiting period for replacement from last service performed on the same tooth. Age limitations apply, refer to Section 6.4.
Prosthodontics Bridges Partial Dentures Complete Dentures	50%	Five year replacement from the date the last restorative/prosthodontic service was performed on the same tooth
Bridge Repair	50%	Once every two years from the date the procedure was last performed.
Denture Repair	50%	Once every two years from the date the procedure was last performed.
Implants	50%	Limited to a lifetime maximum of $1,000 per tooth
Orthodontic Services **Services do not apply to annual benefit maximum**		
Adults & children age eight (8) and older	50%	Limited to a lifetime maximum of $1,500 per member. Any mail order orthodontic treatment (i.e. Smile Direct) is not covered.

6.2 Annual Benefit Maximum

The Annual Benefit Maximum is the total dollar amount that the Plan will pay for dental services rendered during any one (1) Benefit Year. This Annual Benefit Maximum applies to each Covered Person per Benefit Year. Please refer to the Summary Dental Benefits and Covered Services chart for the dental services that are applied to the Annual Benefit Maximum.

You cannot transfer all or any portion of your Annual Benefit Maximum from person to person or year to year.

6.3 Annual Deductible

Deductible is the amount of covered dental expenses that you pay before the dental benefits are payable and applies to each Covered Person per Plan Year. Only fees charged for covered dental services will be used toward the deductible. How the deductible works:

1. When covered dental expenses equal to the deductible amount have been incurred and submitted to Delta Dental, the deductible will be satisfied.
2. Delta Dental will not pay benefits for covered dental services applied to the deductible.
3. There is one common deductible amount for the Participating and Non-participating Dentists.
4. The deductible is for a Benefit Year and is calculated on the date of service.
5. The lesser of Delta Dental allowance or billed charges for covered services will count toward the deductible.
6. Charges incurred for dental services that are not covered during a Benefit Waiting Period will not be applied toward the deductible.

6.4 Crowns and Onlays

The crown, onlay, inlay, veneer or gold foil service is available to patients 12 years and older and have a five (5) year replacement from the date last performed on the same tooth.

A. Crowns and onlays are covered as follows:
    1. Only when the teeth cannot be restored with fillings due to severe loss of hard tooth structure as a result of decay or fracture. This excludes loss of tooth structure, fractures, and damage to either hard or soft tissues due to attrition, erosion, abrasion (wear), bruxism and/or as a result of a device worn in a tongue or lip piercing.
    2. The date of service for crowns and onlays is on the preparation date.
    3. Once in a five (5) year period from the date this procedure was last performed on the same tooth.
    4. Only when no other professionally acceptable form of treatment can be performed.
    5. Only when necessary to retain a cast restoration due to extensive loss of tooth structure.
    6. Crown build-ups (pin, bonded, or post and core) are a benefit once in a five (5) year interval from the date this procedure was last performed on the same tooth.
    7. When provided for patients twelve (12) years of age or older. An allowance of a preformed crown will be beneficial for patients under 12 years of age.
    8. Porcelain/ceramic crown will apply an alternate benefit of a porcelain fused to high noble metal crown.
B. Veneers are not a covered benefit. An alternate benefit of a crown will be provided; if it is determined the tooth could not be restored with fillings due to severe loss of hard tooth structure as a result of decay or fracture. This excludes loss of tooth structure, fractures, and damage to either hard or soft tissues due to attrition, erosion, abrasion (wear), bruxism and/or as a result of a device worn in a tongue or lip piercing.
C. Inlays are not a covered benefit; an alternate benefit of a filling would be available
D. Gold foils are not a covered benefit; an alternate benefit of a filling would be available
E. Build-ups are covered as follows:
    1. Crown build-ups (pin, bonded, or post and core) are a benefit once in a five (5) year interval from the date this procedure was last performed on the same tooth.
    2. Crown build-ups are a benefit only when necessary to retain a cast restoration due to extensive loss of tooth structure.

6.5 Diagnostic X-Ray Services

Full-mouth x-ray series/panoramic film, vertical bitewings are a benefit once in a three (3) year interval from the date this procedure was last performed.

Bitewing x-rays are a benefit once in a Plan Year. Periapicals are covered as needed.

6.6 Emergency Palliative Treatment

Emergency palliative treatment is covered for the relief of pain. Palliative treatment is not covered if definitive treatment is performed for the same problem on the same date. Examination and x-rays are not considered a relief of pain.

6.7 Endodontics

Benefits will be provided for necessary procedures for pulpal therapy in primary (baby) teeth (pulpotomy) and root canal treatment of infected tooth pulp (nerve) in permanent teeth.

Endodontic benefits as described above are benefited once per tooth. Benefits for additional endodontic procedures, such as retreatment, are a benefit once in a three (3) year interval from the date of the last procedure for that tooth.

The date of service is the date the Root Canal is completed.

6.8 Examinations, Evaluations or Consultations

Two (2) periodic or comprehensive exams during a Plan Year.

One (1) Problem Focused Emergency Examination, Evaluation or Consultation during a Plan Year.

6.9 Fillings

Fillings consisting of silver amalgam and/or composite tooth colored fillings are covered.

Fillings are a benefit once for each tooth surface in a twenty-four (24) month interval from the date this service was last performed on that specific tooth surface.

6.10 Foreign Claims

Coverage for foreign dental services are provided when performed in a dental office and completed by a licensed Dentist. A claim form must be submitted to Delta Dental for reimbursement and must include the following information: Employee name, member identification number, patient name, date of birth, date of service, provider name, professional license and address, detailed description of the services rendered on dental practice letterhead, charges, copies of the pre-operative x-ray, and conversion of the currency reported. Contact Delta Dental of Arizona to verify the professional license of a dental professional.

6.11 Fluoride treatment

Fluoride treatment is a benefit twice in a Plan Year. Fluoride treatment covered up to the age of eighteen (18).

6.12 General Anesthesia and Intravenous Sedation/Analgesia

Benefits for general anesthesia and intravenous sedation/analgesia will be provided only if the following conditions are met:

1. Performed by a Dentist licensed to perform general anesthesia;
2. Administered in a dental office;
3. When performed in conjunction with covered Oral and Maxillofacial Surgery Procedures (excluding routine extractions and removal of coronal remnants). Payment is based on the

submitted dental codes for the actual procedures, not for complicating factors, such as swelling or infection.

4. Necessary due to medically concurrent conditions, (i.e., neurological motor control problems) and documented by a medical physician.

6.13 Implant Benefit

Implant procedures (surgical placement and connecting rod) are subject to both the benefit year allowance and the lifetime maximum limit of $1,000 per tooth. These procedures will be beneficial when Delta Dental's consultant has determined the treatment is necessary to replace a single missing tooth.

6.14 Implant Supported Crown/Denture

Whether or not your implant procedure (surgical placement and connecting rod) was given a benefit, your implant supported crown/denture would be eligible for a separate benefit as described under Section 6.4 Crowns and Onlays.

6.15 Oral and Maxillofacial Surgery Procedures

Benefits will be provided for extractions and surgical procedures.

Post-treatment care for extractions and surgical procedures is considered to be part of the procedure performed and a separate benefit is not provided.

6.16 Orthodontic Services

Procedures using appliances (non-surgical) to treat misalignment of teeth and/or jaws which significantly interfere with their function.

Benefit payments will be distributed over the course of treatment as follows:

A. An initial payment will be made upon insertion of the appliance or upon initial banding. The initial banding date is considered the date of service for orthodontic services.
B. The second payment will be made twelve (12) months after the insertion or banding date if the patient has current eligibility.
C. Treatment must not begin prior to the age of eight (8).

Orthodontic transition of care coverage is provided if the first active appliance/banding was inserted while under an indemnity/PPO plan prior to your eligibility with this plan. Treatment must still be in progress and the total benefit available was not paid by the previous indemnity/PPO plan. Any payment amounts applied under the prior indemnity/PPO plan will be credited to the current orthodontic benefit maximum.

Payments will be discontinued if treatment and eligibility ceases for any reason.

Orthodontic records (i.e. study molds, photographs, panoramic and cephalometric x-rays) are included as part of the annual benefit maximum.

6.17 Periodontics

1. Benefits will be provided for treatment of diseases of the tissues supporting the teeth (gingival and/or alveolar bone).

2. Periodontal Scaling is a benefit once in a two (2) year interval from the date this procedure was last performed.
3. Periodontal Root Planing is a benefit once in a two (2) year interval from the date this procedure was last performed on specific teeth or quadrants.
4. Surgical periodontal treatment is a benefit once in a three (3) year interval from the date this procedure was last performed on those specific teeth or quadrants.
5. Full Mouth Debridement (difficult prophylaxis) may be exchanged for one (1) routine cleaning and is a benefit once in a five (5) year interval from the date this procedure was last performed.
6. Periodontal bone grafting for natural teeth only.

6.18 Preformed Crowns

1. Preformed crowns are a benefit once in a two (2) year interval from the date this procedure was last performed on specific primary (baby) teeth.
2. Preformed crowns are a benefit once in a five (5) year interval from the date the procedure was last performed on specific permanent teeth.

6.19 Prosthetic Services Removable and Fixed Appliances

1. The date of service for a removable appliance is the delivery date. The date of service for a fixed appliance is the date of preparation.
2. Provides bridges, partial dentures and full dentures for replacement of fully extracted or missing teeth.
3. Adjustments to complete or partial dentures are limited to two (2) adjustments per denture, per twelve (12) months (after six months has elapsed since initial placement of the denture).
4. Dentures, removable partials and fixed bridges are a benefit once in a five (5) year interval from the date this procedure was last performed.
5. Relines and rebases are a benefit once in a two (2) year interval from the date this procedure was last performed.
6. Temporary partial denture (flipper) for replacement of any of the permanent anterior teeth is a benefit once in a lifetime, per arch. For patients under the age of seventeen (17), only a benefit for missing permanent anterior teeth.
7. A fixed prosthesis is not a benefit under the age of sixteen (16).

6.20 Routine Cleaning

Routine prophylaxis is a benefit twice in a Plan Year. Routine prophylaxis and periodontal prophylaxis are considered to be interchangeable services. A patient must have documented periodontal history to receive a periodontal maintenance benefit (excluding full mouth debridement).

Please refer to Periodontics for full mouth debridement (difficult prophylaxis).

6.21 Sealants

1. Sealants are covered benefits up to the age of nineteen (19).
2. Sealants are a benefit once in a three (3) year interval from the date last performed.
3. Sealants are a benefit for the occlusal surface (free from caries or restorations) on permanent bicuspids, first and second molars.

6.22 Space Maintainers

Space maintainers due to the premature loss of diseased posterior primary (baby) teeth. Space maintainers for posterior primary (baby) teeth are covered up to the age of fourteen (14).

Anterior space maintainers are not a covered benefit.

6.23 Specific Benefit Maximum

Some benefits may have a specific lifetime maximum. No benefits will be paid over the maximum amount specified in this benefit provision.

ARTICLE 7

EXCLUSIONS AND GENERAL LIMITATIONS

7.1 Exclusions

1. Services for injuries or conditions which are compensable under Workers' Compensation or Employer's Liability Law, services which are provided to the Covered Person by any Federal or State Government Agency or are provided without cost to the Covered Person by any municipality, county or other political subdivision, or community agency.
2. A service or procedure that is not generally accepted by the American Dental Association and Delta Dental's processing policies.
3. A service or procedure that is not described as a benefit of this plan.
4. A method of treatment more costly than is customarily provided. Benefits will be based on the least expensive professionally accepted method of treatment.
5. Dental and surgical services with respect to cosmetic surgery or dentistry for purely cosmetic reasons.
6. Specialized techniques including but not limited to precious metal for removable appliances, precision attachments for partials or bridges, overdentures, overlays, implantology as well as procedures and appliances associated with the preceding procedures in addition to personalization and characterization.
7. Charges for any health care not specifically covered under this Employer Group Dental Contract including hospital charges, prescription drug charges, and laboratory charges or fees.
8. Charges for dental services which are started prior to the date the person became covered under the plan or which are performed during the Benefit Waiting Period.
9. Procedures, appliances or restorations that are necessary to alter, restore or maintain occlusion, including but not limited to: altering vertical dimension, replacing or stabilizing tooth structure lost by attrition, erosion, abrasion wear or bruxism, realignment of teeth, periodontal splinting, splinting, gnathologic recordings, equilibration, bite appliances or harmful habit appliances and/or other damage to either hard or soft tissues as a result of a device worn in a tongue or lip piercing is not a covered benefit.
10. Temporary dentures, other than those provided in this plan.
11. Study models, casts and other ancillary services not covered in this plan unless orthodontics is included as a covered benefit.
12. Travel time and related expenses.
13. Orthodontic services except when covered by the plan.
14. Direct diagnostic or surgical and non-surgical treatment procedure applied to body joints or muscles, temporomandibular joint (TMJ) or temporomandibular disturbances (TMD).
15. Delta Dental will not pay for any claim received more than twelve (12) months from the date of service or twelve (12) months after the termination of the plan whichever comes first.
16. Delta Dental will not pay for any adjustments to previously received claims, including submissions of additional information, received more than twelve (12) months from the initial payment date or initial date issue date of the requested information.
17. Experimental or transitional procedures or any procedure other than those covered services.
18. Myofunctional therapy or speech therapy.
19. Services not performed in accordance with the laws of the State of Arizona, services performed by any person other than a person authorized by dental license to perform such services, or

services performed to treat any condition, other than an oral or dental disease, malformation, abnormality or condition as explained.

20. Completion of forms, providing diagnostic information or records, or duplication of x-rays or other records.
21. Replacement of lost, stolen or damaged dental appliances.
22. Procedures or services performed in conjunction with uncovered dental services.
23. Coverage for crowns excludes loss of tooth structure, fractures, and damage to either hard or soft tissues due to attrition, erosion, abrasion (wear), and bruxism and/or as a result of a device worn in a tongue or lip piercing.
24. General anesthesia and intravenous sedation/analgesia for an anxiety, behavioral or management problem.
25. Repair or replacement of an orthodontic appliance that is broken or lost, for any reason.
26. Orthodontic benefits exclude removable or fixed appliances therapy to control harmful habits.
27. Orthodontic work in progress that has been performed under a dental health maintenance organization (DHMO) or discount plan.
28. Post and core coverage for onlays.
29. All other services not specified as covered dental service.
30. Any mail order orthodontic treatment (i.e. Smile Direct).

7.2 General Limitations

1. If an eligible person with a covered condition selects a service that is not provided for under the terms of this plan, or selects specialized techniques rather than standard dental services, Delta Dental will pay the applicable percentage of the allowable fee for the standard covered dental service and the patient is responsible for the difference between what Delta Dental paid and the dentist's fee.
2. Pre- and post-operative procedures are considered part of any associated covered service. Benefit will be limited to the covered amount for the covered services.
3. Local anesthesia is considered a component of any procedure in which it is used.
4. A temporary dental service will be considered an integral part of a complete service rather than a separate service, and separate payment will not be made for a temporary service unless otherwise included as a covered service of this Plan.
5. If a Covered Person transfers from the care of one (1) dentist to that of another dentist during a course of treatment, Delta Dental will not pay for more than the amount it would have paid for had only one (1) dentist rendered all the dental services during each course of treatment. Delta Dental will not pay for duplication of dental services.
6. Even if your dentist has: prescribed, recommended or provided the service, it does not necessarily make the procedure eligible for benefits even though it is not expressly excluded in this plan description. Regardless of dental or medical necessity, not all treatments and services recommended or performed by your dentist are covered benefits.
7. If you or any of your dependents have received free services by or through a public program, Delta Dental will coordinate benefits based on submitted documentation.
8. When an alternate benefit allowance is given, the alternate procedure allowed is subject to the time limitations of the procedure benefited.
9. Implants, materials implanted or grafted into or onto bone or soft tissue, or removal of implants, are not a covered benefit except when covered by this plan.
10. When a procedure is benefited, and then a new service is performed on the same tooth, it is subject to the time limitations of the prior service; therefore, benefits will be reduced on the new service.

11. Sterilization fees are considered a component of any procedure in which it is used.
12. If a covered service is subject to a benefit waiting period and the treatment begins prior to the completion of the waiting period (excluding orthodontic transition of care), no benefit is allowed.

ARTICLE 8

COORDINATION OF BENEFITS AND OTHER SOURCES OF PAYMENT

8.1 Coordination of Benefits

Delta Dental coordinates the benefits under this program with you or your dependents' benefits under any other group managed care program or insurance policy. Benefits under one (1) of these programs may be reduced so that your combined coverage does not exceed the Maximum Reimbursable Amount or non-participating dentist allowable fee for the covered service. If this plan is the "primary" program, Delta Dental will not reduce benefits, but if the other program is primary, Delta Dental may reduce benefits. The reduction will be the amount paid under the terms of the primary program if it exceeds Delta Dental's Maximum Reimbursable Amount. Refer to Covered Dental Services in the Summary of Benefits and Covered Services Article 6.

8.2 Determination of Primary Program

If a person is eligible for benefits under two (2) or more programs and more than one (1) of the programs provides coverage for an allowable benefit, Delta Dental will pay according to the Determination of the Primary Program stated below:

A. The program covering the patient as a Subscriber is primary over a program covering the patient as a Covered Dependent.
B. When the patient is a dependent child, then the birthdays of the parents determine which program is primary. The program of the parent whose birthday (month and day, not year) occurs earlier in a calendar year is primary and will pay its benefits first. The program covering the parent whose birthday occurs later in the year is secondary.
C. When the parents of a dependent child are legally separated or divorced, the program covering the parent with legal custody is primary. The program covering the spouse of the parent with custody (i.e. stepparent) is next. The program of the parent not having legal custody is last. However, if there is a court decree assigning the responsibility for healthcare expenses of the child to one (1) parent, then the program covering that parent is primary.
D. If the patient is a member of a prepaid dental plan or other capitation plan and is also a Covered Person under this Employer Group Dental Contract then this Employer Group Dental Contract is primary, without regard to the existence of such other plan. Delta Dental will not be obligated to pay, however, for any dental services that are covered without charge under the prepaid or other capitation plan or to pay in excess of the amount of the co-payment obligation for the particular service under the prepaid or other capitation plan.
E. The program covering the patient as an employee (or as that employee's dependent) is primary over the program covering the patient as a laid off or Retired Employee (or that employee's dependent).
F. If the above rules do not apply, or if there are two (2) "primary" coverage plans due to retirement, then the program covering the patient longer is primary.

8.3 Subrogation and Right of Reimbursement Recovery

This provision applies whenever any payments are made pursuant to this Plan, to or for the benefit of any person covered by the Plan (for purposes of this provision only, such person shall be referred to herein as "Covered Person" and includes, but is not limited to the Covered Person's dependents, spouse, children or other individuals in any way connected to the Covered Person to whom or for whose benefit

any payments have been made under this Plan, the Member himself or herself, and all their heirs, legatees, administrators, executors, beneficiaries, successors, assigns, personal representatives, next friends, and any other representatives of such Covered Person). Such Covered Person has or may have any claim or right to recover any damages from any person or entity, including but not limited to, any tortfeasor, anyone vicariously liable for such tortfeasor, any tortfeasor's insurance company, any uninsured motorist insurance carrier, any underinsured motorist insurance carrier, and any others who are or may be liable for damages to the Covered Person (for purpose of this provision only, such person or entity shall hereinafter be collectively referred to as the "Third Party") as a result of any negligent or other wrongful act of anyone. In the event of any such payments under the Plan, the Plan shall, to the full extent of such payments, and in an amount equal to what the Plan paid, be subrogated to all rights of recovery of the Covered Person against such Third-Party. The Plan, either in conjunction with or independently of the Covered Person, shall be entitled to recover all such payments from the Third-Party. (This is the Plan's right of subrogation).

In addition to and separate from the above-described right of subrogation, in the event of any payments under the Plan to or for the benefit of any Covered Person, the Covered Person agrees to reimburse the Plan to the full extent of such payments, and in an amount equal to what the Plan paid, from any and all amounts recovered by the Covered Person from any Third Party by suit, settlement, judgment or otherwise, whether such recovery by the Covered Person is in part or full recovery of the damages incurred by the Covered Person. (This is the Plan's right of reimbursement.)

The above-described right of subrogation and right of reimbursement are not subject to offset or other reduction by reason of any legal fees or other expenses incurred by the Covered Person in pursuing any claim or right. The Plan is entitled to recover in full all such payments in subrogation and/or pursuant to the right of reimbursement first and before any payment whatsoever by the Third Party to or for the benefit of the Covered Person. The right of subrogation and/or right of reimbursement of the Plan supersedes any rights of the Covered Person to recover from any Third-Party, including situations where the Covered Person has not been fully compensated for all the Covered Person's damages. The priority of the Plan to be paid first exists as to all damages received or to be received by the Covered Person, and to any full or partial recovery by the Covered person. The Covered Person agrees that the Covered Person's right to be made whole is superseded by the Plan's right of subrogation and/or right of reimbursement.

The Covered Person agrees to fully cooperate with the Plan in any effort by the Plan to recover pursuant to its rights of subrogation and/or reimbursement, and the Covered Person further agrees to do nothing to prejudice such rights. The Covered Person agrees to provide information to the Plan necessary for the Plan to pursue such rights, and further agrees, if requested by the Plan, to acknowledge in writing the rights of the Plan to recover following any injury or illness giving rise to any payments under the Plan. If requested to do so by the Plan, the Covered Person agrees to assign in writing to the Plan the Covered Person's right to recover against any Third-Party without the Plan having been paid in full, then the Covered Person agrees to hold such payment in trust for the Plan and promptly notify the Plan in writing that the Covered Person is holding such funds and will release such funds to the Plan upon request by the Plan. The Covered Person further agrees to promptly notify the Plan in writing of the commencement of any litigation or arbitration seeking recovery from any Third-Party, and further agrees not to settle any claim against any Third-Party without first notifying the Plan in writing at least fourteen days before such settlement so the Plan may take actions it deems appropriate to protect its right of subrogation and/or right of reimbursement. In the event the Covered Person commences any litigation

against any Third Party, the Covered Person agrees to name the Plan as a party to such litigation so as to allow the Plan to pursue its right of subrogation and/or right of reimbursement.

8.4 Statutory Liens

Arizona law prohibits Participating Providers from charging you more than the applicable copayment or other amount you are obligated to pay under this Plan for covered services. However, Arizona law also entitles certain Providers to assert a lien for their customary charges for the care and treatment of an injured person upon any and all claims of liability or indemnity, except health insurance. This means that if you are injured and have a claim against a non-health liability insurer (such as automobile or homeowner insurance) or any other payor source for injuries sustained, a Provider may be entitled to a lien against available proceeds from any such insurer or payor in an amount equal to the difference between: (1) the applicable Member co-payment plus what the Participating Provider has received from Plan as payment for covered services, and (2) the Participating Provider's full billed charges.

8.5 Fraud

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit will lose all benefit coverage under any Plan offered by ADOA. You will not be eligible to re-enroll at a future date. Amounts paid on these claims may be deducted from your pay until all funds have been reimbursed to ADOA.

ARTICLE 9

CLAIM FILING PROVISIONS AND APPEALS PROCESS

In cases where a claim for benefits payment is denied in whole or in part (including determinations of eligibility, coverage terminations, rescissions, or any Adverse Benefit Determination) the Member may appeal the denial or decision.

9.1 Discretionary Authority

The Plan Sponsor delegates to Delta Dental the discretionary authority to apply plan terms and to make factual determinations in connection with its review of claims under the plan. Such discretionary authority is intended to include, but not be limited to, the computation of any and all benefit payments. The Plan Sponsor also delegates to Delta Dental the discretionary authority to perform a full and fair review of each claim denial which has been appealed by the claimant or his duly authorized representative.

9.2 Claims Filing Procedure

The following claim definitions have special meaning when used in this Plan in accordance with Claim Procedures and Appeal Procedures.

A "Claim" is any request for a Plan benefit or benefits made by a Member or by an authorized representative of the Member in accordance with the Plan's procedures for filing benefit claims.

An "Urgent Care Claim" is a claim for dental care to which applying the time periods for making pre-service claims decisions could seriously jeopardize the claimant's life, health or ability to regain maximum function or would subject the claimant to severe pain that cannot be adequately managed without the care that is the subject of the claim. If the treating Physician determines the claim is "urgent," the Plan must treat the claim as urgent.

A "Pre-Service Claim" is a request for approval of a benefit in which the terms of the Plan condition the receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining dental care. Examples of a Pre-Service Claim include but are not limited to a Pre-Certification of general items or health services or a request for Predetermination to determine coverage for a specific procedure.

A "Post-Service Claim" is a claim that under this Plan is not a Pre-Service Claim (i.e., a claim that involves consideration of payment or reimbursement of costs for dental care that has already been provided).

Requests for determinations of eligibility or general inquiries to the availability of particular Plan benefits or the circumstances under which benefits might be paid under the terms of the Plan will not be treated as a claim for benefits for the purposes of the Claim Procedures.

9.3 Notice of Claim – Post-Service Claims

In order to promptly process Post-Service Claims and to avoid errors in processing that could be caused by delays in filing, a written proof of loss should be furnished to Delta Dental as soon as reasonably possible. In no event, except in the absence of legal incapacity of the claimant, may proof be furnished later than one (1) year from the date upon which an expense was incurred. Except as indicated in the

preceding sentence, Post-Service Claims will be barred if proof of loss (filing initial claim) is not furnished within one (1) year from the date incurred.

It is the responsibility of the Member to make certain each Post-Service Claim submitted by him or on his behalf includes all information necessary to process the claim, and that the Post-Service Claim is sent to the proper address for processing (the address on the Member's ID Card). If a Post-Service Claim lacks sufficient information to be processed, or is sent to an incorrect address, the Post-Service Claim will be denied.

9.4 Initial Claim Determination

Provided a Member files a claim for benefits in accordance with the terms of the Plan specific to each type of claim, the Plan will make an initial claim determination:

1. Within three (3) business days after receipt of an Urgent Care Claim by the Plan. This notice if adverse, must be provided to you in writing within 3 days of any oral communication;
2. Within fifteen (15) calendar days after receipt of a Pre-Service Claim by the Plan. This notice if adverse, must be provided in writing;
3. Within thirty (30) calendar days after receipt of a Post-Service Claim by the Plan.

The time periods above are considered to commence upon Delta Dental receipt of a claim for benefits filed in accordance with the terms of the Plan specific to each type of claim, without regard to whether all of the information necessary to decide the claim accompanies the filing.

If a claim on review is wholly or partially denied, the written notice will contain the following information:

1. The specific reason(s) for the denial and reference to the specific Plan provisions on which the denial is based. If a protocol was followed in making the determination, then the notice will state that a protocol was relied upon and that a copy of such protocol is available to the Member free of charge upon request. If the claim was denied because it does not meet the definition of a Covered Expense or is experimental in nature, or if denial is due to a similar exclusion or limit, then the notice will state that an explanation of the scientific or clinical judgment used in applying the terms of the Plan to the Member's dental circumstances can be provided free of charge to the Member upon request, including the names of any dental professionals consulted during the review process.
2. A statement that the Member is entitled to request, free of charge, reasonable access to all documents, records, and other information relevant to the Member's claim.
3. A statement notifying the Member about further appeal processes available, as established by Delta Dental.

Any written notice, acknowledgment, request, decision or other written document that is sent by mail is deemed received by the person to whom the document is properly addressed on the fifth business day after mailing.

9.5 Claims Appeal Procedures

In cases where a claim for benefits payment is denied in whole or in part, the Member may appeal the denial. This appeal provision will allow the Member to request from the Plan a review of any claim for benefits. Such request must include:

1. Employee name;
2. Covered Employee's Member ID;
3. Name of the patient; and
4. Group/Client Identification number from the Member's ID card.

Request for review must be in writing, stating in clear and concise terms the reason or reasons for this disagreement with the handling of the claim. Submit written comments, documents, records, and other information relating to the claim. Request, free of charge, reasonable access to documents, records, and other information relevant to the Member's claim. A document, record or other information is considered relevant if it was relied on in making the benefit determination; was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied on in making the benefit determination; demonstrates compliance with the Plan's administrative processes and consistency safeguards required in making the benefit determination; or constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

The initial request for review must be directed to Delta Dental within 180 days after the date you receive notification of the adverse decision or rescission. In the case of Urgent Care Claims, a request for an expedited review may be submitted orally and all necessary information, including the Plan's benefit determination upon review, may be transmitted between the Plan and Member via telephone, facsimile, or other available similarly expeditious methods. Expedited appeals may be filed orally by calling Delta Dental.

The review of the denial will be made by the Plan, or by an appropriately named fiduciary who is neither the party who made the initial claim determination nor the subordinate of such party. The review will not defer to the initial claim determination and will take into account all comments, documents, records and other information submitted by the Member without regard to whether such information was previously submitted or relied upon in the initial determination. In deciding an appeal of any denied claim that is based in whole or in part on a dental judgment, Delta Dental must consult with an appropriately qualified dental care professional who is neither an individual who was consulted in connection with the denied claim that is the subject of the appeal nor the subordinate of any such individual.

Delta Dental will provide the Member with a written response:

1. Within 72 hours after receipt of the Member's request for review in the case of Urgent Claims;
2. Within fifteen (15) calendar days after receipt of the Member's request for review in the case of Pre-Service Claims;
3. Within forty-five (45) calendar days after receipt of the Member's request for review in the case of Post-Service Claims.

If a claim on review is wholly or partially denied, the written notice will contain the following information:

1. The specific reason(s) for the denial and reference to the specific Plan provisions on which the denial is based. If a protocol was followed in making the determination, then the notice will

state that a protocol was relied upon and that a copy of such protocol is available to the Member free of charge upon request. If the claim was denied because it does not meet the definition of a Covered Health Service or is experimental in nature, or if denial is due to a similar exclusion or limit, then the notice will state that an explanation of the scientific or clinical judgment used in applying the terms of the Plan to the Member's dental circumstances can be provided free of charge to the Member upon request, including the names of any dental professionals consulted during the review process.

2. A statement that the Member is entitled to request, free of charge, reasonable access to all documents, records, and other information relevant to the Member/Participant's claim.
3. A statement notifying the Member about potential alternative dispute resolution methods, if any.

Any written notice, acknowledgment, request, decision or other written document that is sent by mail is deemed received by the person to whom the document is properly addressed on the fifth business day after mailing.

9.6 Levels of Standard Appeal and Responsibility of Review

Level 1 is an initial appeal filed by the Member in regard to a denial of services. The Level 1 appeal must be filed within 180 days from the date you receive notification of the adverse decision or rescission. Level 1 appeals are reviewed and responded to by Delta Dental. The staff person reviewing the appeal will not be the person who made the initial decision.

Level 2 is a second appeal filed by the Member in regard to a denial of services in which the denial was upheld during the review of the Level 1 appeal. The Level 2 appeal must be filed within 60 days from the date you receive notification of the Level 1 adverse decision or rescission. Level 2 appeals are reviewed and responded to by Delta Dental. The staff person reviewing the appeal will not be the person who made the initial decision nor the Level 1 appeal decision.

Level 3 is the third appeal filed by the Member in regard to a denial of services in which the denial was upheld during the review of the Level 2 appeal. The Level 3 appeal must be filed within four months from the date you receive notification of the Level 2 adverse decision or rescission. Level 3 appeals are reviewed by an Independent Review Organization (IRO) at no charge to the Member. Delta Dental will respond to the Member with the decision based on the IRO review process.

9.7 Limitation

No action at law or in equity can be brought to recover on this Plan until the appeals procedure has been exhausted as described in this Plan.

No action at law or in equity can be brought to recover after the expiration of two (2) years after the time when written proof of loss is required to be furnished to Delta Dental.

ARTICLE 10

ADMINISTRATION

10.1 Plan Sponsor's Responsibilities

The Plan Sponsor shall have the sole and final authority and responsibility for the Plan and its operation, including the authority and responsibility for establishing, administering, construing, and interpreting the provisions of the Plan and making all determinations thereunder. This includes:

1. Calling and attending the meetings at which this Plan's funding policy and method are established and reviewed;
2. Establishing the policies, interpretations, practices and procedures of this Plan and issuing interpretations thereof;
3. Hiring all persons providing services to this Plan;
4. Decide all questions of eligibility;
5. Receiving all disclosures required of fiduciaries and other service providers under federal or state law; and
6. Performing all other responsibilities allocated to the Plan Sponsor in the instrument appointing the Plan Sponsor.

10.2 Delta Dental Responsibilities

The Plan Sponsor has delegated some of its administrative responsibilities to Delta Dental. Delta Dental generally provides reimbursement services only and does not assume any financial risk or obligation with respect to claims for benefits payable by the Plan Sponsor under the Plan. Delta Dental shall have the authority and responsibility for:

1. Acting as this Plan's agent for the service of legal process;
2. Applying this Plan's provisions relating to coverage, including when a claimant files an appeal under the Plan;
3. Administering this Plan's claim procedures;
4. Rendering final decisions on review of claims as required by the application of this Plan Description;
5. Processing checks for Benefits in accordance with Plan provisions. Plan Sponsor is responsible for payment of claims made pursuant to, and Benefits to be provided by, the Plan. Delta Dental does not insure or underwrite the liability of the Plan Sponsor under the Plan or assume any responsibility for the adequacy of its funding;
6. Filing claims with the insurance companies, if any, who issue stop loss insurance policies to the Plan Sponsor; and
7. Performing all other responsibilities delegated to Delta Dental in the instrument appointing Delta Dental.

Delta Dental acting as the claims fiduciary will have the duty, power, and authority to apply the provisions of this Plan, to make factual determinations in connection with its review of claims under the Plan, and to determine the amount, manner, and time of payment of any Benefits under this Plan. All

applications of the provisions of this Plan, and all determinations of fact made in good faith by Delta Dental, will be final and binding on the Members and beneficiaries and all other interested parties.

Delta Dental is an independent contractor with respect to the services being performed and shall not be deemed an employee of the Plan Sponsor, nor shall Delta Dental shall be deemed a partner, engaged in a joint venture, or governed by any legal relationship other than that of an independent contractor. Delta Dental does not assume any responsibility for the general design of the Plan or any act or omission or breach of duty by the Plan Sponsor.

10.3 Advisors to Fiduciaries

A named fiduciary or his delegate may retain the services of actuaries, attorneys, accountants, brokers, employee benefit consultants, and other specialists to render advice concerning any responsibility such fiduciary has under this Plan.

10.4 Multiple Fiduciary Functions

Any named fiduciary may serve in more than one fiduciary capacity with respect to this Plan.

10.5 Notice of Appointments or Delegations

A named fiduciary shall not recognize or take notice of the appointment of another named fiduciary, or the delegation of responsibilities of a named fiduciary, unless and until the Plan Sponsor notifies the named fiduciary in writing of such appointment or delegation. The named fiduciaries may assume that an appointment or delegation continues in effect until the named fiduciary receives written notice to the contrary from the Plan Sponsor.

10.6 Written Directions

Whenever a named fiduciary or delegate must or may act upon the written direction of another named fiduciary or delegate, the named fiduciary or delegate is not required to inquire into the propriety of such direction and shall follow the direction unless it is clear on its face that the actions to be taken under that direction would be prohibited under the terms of this Plan. Moreover, such named fiduciary or delegate shall not be responsible for failure to act without written directions.

10.7 Co-Fiduciary Liability

A fiduciary shall not have any liability for a breach of fiduciary duty of another fiduciary, unless he participates knowingly in such breach, knowingly undertakes to conceal such breach, has actual knowledge of such breach and fails to take action to remedy such breach, or, through his negligence in performing his own specific fiduciary responsibilities, enables such other fiduciary to commit a breach of the latter's fiduciary duty.

10.8 Action by Plan Sponsor

Any authority or responsibility allocated or reserved to the Plan Sponsor under this Plan may be exercised by any duly authorized officer of the Plan Sponsor.

ARTICLE 11

LEGAL NOTICES

11.1 HIPAA Privacy Regulation Requirements

This Plan has been modified as required under the Administrative Simplification requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), to allow the Disclosure of Protected Health Information (PHI) as defined under HIPAA, to the Plan Sponsor and other parties as necessary to determine appropriate processing of claims.

Please refer to the Benefit Options Guide for details on the use of PHI.

11.2 Notice of Special Enrollment Rights for Health Plan Coverage

If you decline enrollment in the State of Arizona's health plan for you or your Dependents (including your Spouse) because of other health insurance or group health plan coverage, you or your Dependents may be able to enroll in the State of Arizona Employee's health plan without waiting for the next Open Enrollment period if you:

- Lose other health insurance or group health plan coverage. You must request enrollment within 31 days after the loss of other coverage.
- Gain a new Dependent as a result of marriage, birth, adoption or placement for adoption. You must request health plan enrollment within 31 days after the marriage birth, adoption, or placement for adoption.
- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible. You must request medical plan enrollment within 60 days after the loss of such coverage.

If you request a change due to a special enrollment event within the 31-day timeframe, coverage will be effective on the date of birth, adoption or placement for adoption. For all other events, coverage will become effective the first day of the next month following your request for enrollment. In addition, you may enroll in the State of Arizona's health plan if you become eligible for a state premium assistance program under Medicaid or CHIP. You must request enrollment within 60 days after you gain eligibility for medical plan coverage. If you request this change, coverage will become effective the first day of the next month following your request for enrollment. Specific restrictions may apply, depending on federal and state law.

Note: If your Dependent becomes eligible for special enrollment rights, you may add the Dependent to your current coverage or change to another health plan.

11.3 General COBRA Notice

This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other Members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Benefit Services Division.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a Spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?
COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your Spouse and your Dependent Children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an Employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the Spouse of an Employee, you will become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your Spouse dies;
- Your Spouse's hours of employment are reduced;
- Your Spouse's employment ends for any reason other than his or her gross misconduct;
- Your Spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your Spouse.

Your Dependent Children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-Employee dies;
- The parent-Employee's hours of employment are reduced;
- The parent Employee's employment ends for any reason other than his or her gross misconduct;
- The parent-Employee become entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The Child stops being eligible for coverage under the Plan as a "Dependent Child"

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the Benefit Options Plan, and that

bankruptcy results in a loss of coverage of any Retired Employee covered under the Plan, the Retired Employee will become a qualified beneficiary. The Retired Employee's Spouse, Surviving Spouse, and Dependent Children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

ARTICLE 12

MISCELLANEOUS

12.1 State Law

This Plan shall be interpreted, construed, and administered in accordance with applicable state or local laws to the extent such laws are not preempted by federal law.

12.2 Status of Employment Relations

The adoption and maintenance of this Plan shall not be deemed to constitute a contract between the Employer and its Employees or to be consideration for, or an inducement or condition of, the employment of an Employee. Nothing in this Plan shall be deemed to:

1. Affect the right of the Employer to discipline or discharge any Employee at any time.
2. Affect the right of any Employee to terminate his employment at any time.
3. Give to the Employer the right to require any Employee to remain in its employ.
4. Give to any Employee the right to be retained in the employ of the Employer.

12.3 Word Usage

Whenever words are used in this Plan Description in the singular or masculine form, they shall, where appropriate, be construed so as to include the plural, feminine, or neutral form.

12.4 Titles are Reference Only

The titles are for reference only. In the event of a conflict between a title and the content of a section, the content of a section shall control.

12.5 Clerical Error

No clerical errors made in keeping records pertaining to this coverage, or delays in making entries in such records will invalidate coverage otherwise validly in force, or continue coverage otherwise validly terminated. Upon discovery of any error, an equitable adjustment of any Benefits paid will be made.

ARTICLE 13

PLAN IDENTIFICATION

Name of Plan	State of Arizona Group Dental Plan AZ Benefit Options
Name and Address of Plan Sponsor	Arizona Department of Administration Human Resources Benefits 100 N 15th Avenue, Suite 301 Phoenix, AZ 85007
Sponsor Identification Number	86-6004791
Type of Benefits Provided	See Schedule of Benefits and Covered Services
Type of Plan Administration	Self-Funded Third Party
Funding to Plan	Contributions for this Plan are provided partially by contributions of the Plan Sponsor and partially by contributions of Covered Employees
End of Plan's Year:	December 31st of each year
Agent for Legal Process/Named Fiduciary	Delta Dental of Arizona
Claims Address	Attn: Claims Department P.O. Box 9092 Farmington Hills, MI 48333-9092 85080-3026
Appeal Address	Attn: Group Plan Appeals P.O. Box 9219 Farmington Hills, MI 4833-9219
Phone	1-866-978-2839
Fax	602-588-3910
TDD/TTY	English 602-588-3903 Spanish 602-588-3920
Website	**www.deltadentalaz.com/adoa**
Policy Number	77777

ARTICLE 14

DEFINITIONS

This section contains definitions of words and phrases which are contained within this Plan Description. Inclusion of service definitions does not imply that expenses related to those services are covered under the Plan.

AGENCY shall mean a department, university, board, office, authority, commission, or other governmental budget unit, of the State of Arizona.

AGENCY LIAISON shall mean the individual within each agency designating as the local Benefit Options representative.

ALTERNATE BENEFIT shall mean a provision in a dental contract that allows a third-party payer to determine the benefit based on an alternative procedure that is generally less expensive than the one provided or proposed. In some cases, the patient would be responsible for cost differences.

ARIZONA ADMINISTRATIVE CODE (A.A.C.) shall mean administrative rules promulgated by state agencies to govern the implementation of statutory intent and requirements.

ARIZONA REVISED STATUTE (A.R.S.) shall mean a law of the State of Arizona.

BENEFIT shall mean the payment or reimbursement by this Plan of all or a portion of a dental expense incurred by a participant.

CHILD shall mean a person who falls within one or more of the following categories:

1. A natural child, adopted child, or stepchild of the member who is younger than age 26;
2. A child who is younger than age 26 for whom the member has court-ordered guardianship;
3. A foster child of the member who is younger than age 26;
4. A child who is younger than age 26 and placed in the member's home by court order pending adoption; or
5. A natural child, adopted child, or stepchild of the member who has a disability prior to age 26 and continues to have a disability under 42 U.S.C. 1382c and for whom the member had custody prior to age 26.

COBRA shall mean the Consolidated Omnibus Budget Reconciliation Act of 1986, as amended. This is a federal law requiring employers to offer continued dental insurance coverage to employees and dependents whose group health coverage has terminated.

CODE shall mean the United States Internal Revenue Code of 1986, as amended.

COVERED SERVICE shall mean a service which is pre-formed and completed by a licensed dentist in a dental office and when necessary and appropriate as determined by the standards of generally accepted dental practice and eligible for payment under the Plan.

DATE OF SERVICE shall mean the date of service that was/were performed. See Article 6 for more information on specific services dates indicated in this Plan Description.

DAY shall mean calendar day; not 24-hour period unless otherwise expressly noted.

DEDUCTIBLE shall mean the amount of covered dental expenses the participant and dependents must pay each plan year before benefits are payable by the Plan. Only fees charged for covered dental services will apply towards the deductible.

DEPENDENT see ELIGIBLE DEPENDENT.

EFFECTIVE DATE shall mean the first day of coverage.

ELECTED OFFICIAL shall mean a person who is currently serving in office.

ELIGIBLE DEPENDENT shall mean the member's spouse or child.

ELIGIBLE EMPLOYEE shall mean an individual who is hired by the State, including the Universities, and is regularly scheduled to work at least 20 hours per week for at least 90 days. Eligible employee does not include:

1. A patient of inmate employed at a state institution
2. A non-state employee, officer or enlisted personnel of the National Guard of Arizona
3. A seasonal employee, unless they are determined to have been paid for an average of at least 30 hours per week using a 12-month measurement period
4. A variable hour employee, unless they are determined to have been paid for an average of at least 30 hours per week using a 12-month measurement period

Persons working for participating political subdivisions may also be considered eligible employees under the respective political subdivision's personnel rules.

ELIGIBLE FORMER ELECTED OFFICIAL shall mean an elected official as defined in A.R.S. § 38-801(3) who is no longer in office and who falls into one of the following categories:

1. Has at least five years of credited service in the Elected Officials' Retirement Plan;
2. Was covered under a group health or group health and accident plan at the time of leaving office;
3. Served as an elected official on or after January 1, 1983; and
4. Applies for enrollment within 31 days of leaving office or retiring.

ELIGIBLE RETIREE shall mean a person who retired under a state-sponsored retirement plan and has been continuously enrolled in the Plan since time of retirement or a person who receives long-term disability benefits under a state-sponsored plan.

EMPLOYEE see ELIGIBLE EMPLOYEE.

EMPLOYER shall mean the State of Arizona, one of the state universities, or a participating political subdivision.

ENROLLMENT shall mean a paper form supplied by Benefit Options, a COBRA enrollment form, or an authorized self-service enrollment system.

EXPLANATION OF BENEFITS shall mean a statement sent to participants by Delta Dental following payment of a claim. It lists the service(s) that was/were provided, the allowable reimbursement amount(s), amount applied to the participant's deductible, and the net amount paid by the Plan.

FORMER ELECTED OFFICIAL see ELIGIBLE FORMER ELECTED OFFICIAL

FRAUD shall mean an intentional deception or misrepresentation made by a member or dependent with the knowledge that the deception could result in some benefit to him/her or any other individual that would not otherwise be received. This includes any act that constitutes fraud under applicable federal or state law.

HIPAA shall mean the Health Insurance Portability and Accountability Act of 1996, as presently enacted and as it may be amended in the future. It is a federal law intended to improve the availability and continuity of health insurance coverage.

LIFETIME BENEFIT MAXIMUM shall mean maximum dental benefit available under the plan. See Article 6 for more information specific lifetime benefit maximums applied in the plan.

IN-NETWORK shall mean utilization of services within the network of contracted providers associated with Delta Dental PPO plus Premier Network.

MEMBER shall mean an eligible employee, eligible retiree, or eligible former elected official that pays/contributes to the monthly premium required for enrollment in the Plan. Surviving dependents and surviving children are considered members in certain circumstances.

NATIONAL MEDICAL SUPPORT NOTICE shall mean the standardized federal form used by all state child support agencies to inform an employer that an employee is obligated by court or administrative child support order to provide health care coverage for the child(ren) identified on the notice. The employer is required to withhold any employee contributions required by the health plan in which the child(ren) is/are enrolled.

NETWORK PROVIDER/PARTICIPATING PROVIDER shall mean the group of dental providers contracted for the purposes of providing services at a discounted rate. Delta Dental provides access to these services through their contracted providers. The network vendors do not pay or process claims nor do they assume any liability for the funding of the claims or the plan provisions. The State of Arizona has assumed all liability for claims payments based on the provisions and limitations stated in the Plan Document.

NETWORK shall mean the group of providers that are contracted with the networks associated with Delta Dental for the purpose of performing dental services at predetermined rates and with predetermined performance standards.

OPEN ENROLLMENT PERIOD shall mean the period of time established by the plan sponsor when members may enroll in the Plan or may modify their current coverage choices. When an open enrollment period is designated as "positive," all members must complete the enrollment process.

OUT-OF-NETWORK shall mean the utilization of services outside of the network of contracted dental providers.

OUT-OF-POCKET EXPENSE shall mean a portion of the covered expense for which the participant is financially responsible.

OUT-OF-POCKET MAXIMUM shall mean the most any participant will pay in annual out-of-pocket expenses.

PARTICIPANT shall mean a member or a dependent.

PARTICIPATING PROVIDER/NETWORK PROVIDER shall mean any provider or facility that is contracted with the network for the purpose of performing dental services at predetermined rates and with predetermined performance standards.

PLAN referred to in this document shall mean a period of twelve (12) consecutive months. For active employees, retirees, long term disability (LTD) recipients, former elected officials, surviving spouses of participating retirees, and employees eligibility for normal retirement this period commences on January 1 and ending on December 31. Any and all provisions revised in the Plan Document will become effective January 1 unless specified otherwise.

PLAN SPONSOR shall mean the Benefit Services of the Arizona Department of Administration.

PLAN DESCRIPTION shall mean this written description of the Benefits Options dental program.

PLAN YEAR shall mean a period of twelve (12) consecutive months for which benefits are paid, and limitations, deductibles, and benefit maximums are tracked. The plan year starts January 1st and ends on December 31st.

POTENTIAL MEMBER shall mean an individual who is not currently enrolled in the Plan but who meets the eligibility requirements.

PRE-DETERMINATION shall mean a process where a dentist submits a treatment plan to Delta Dental before treatment begins. Delta Dental reviews the treatment and releases an explanation of payment/benefit to the contracted dentist and the patient. See Article 4 for more information about pre-determinations.

PROVIDER shall mean a duly licensed person or facility that furnishes healthcare services or supplies pursuant to law, provided that each, under his/her license, is permitted to furnish those services.

QUALIFIED LIFE EVENT shall mean a change in a member's or dependent's eligibility, employment status, place of residence, Medicare-eligibility, or coverage options that triggers a 31-day period in which the member is allowed to make specific changes to his/her enrollment options. This includes, but is not limited to:

1. Change marital status such as marriage, divorce, legal separation, annulment, or death of spouse;
2. Change in dependent status such as birth, adoption, placement for adoption, death, or dependent eligibility due to age;
3. Change in employment status or work schedule that affect benefits eligibility;
4. Change in residence that impacts available plan options;
5. Compliance with a qualified medical child support order or national medical support notice;
6. Change in Medicare-eligibility;
7. Change in cost of coverage;
8. Restriction, loss, or improvement in coverage; or
9. Coverage under another employer plan.

QUALIFIED MEDICAL CHILD SUPPORT ORDER shall mean a court order that provides health benefit coverage for the child of the noncustodial parent under that parent's group health plan.

RETIREE see ELIGIBLE RETIREE.

SEASONAL EMPLOYEE shall mean an individual who is employed by the State for not more than six months of the year and whose employment is dependent on an easily identifiable increase in work associated with a specific and reoccurring season. Seasonal employees do not include employees of educational organizations who work during the active portions of the academic year.

SERVICE AREA shall mean the nationwide network offered by Delta Dental.

SPOUSE shall mean the member’s marital partner under Arizona law.

SUBROGATION shall mean the procedure used by the Plan for the purpose of obtaining reimbursement for any payments made for dental services and supplies rendered to a participant as a result of damages, illness or injury inflicted by a third party.

SURVIVING CHILD shall mean the child who survives upon the death of his/her insured parent.

SURVIVING DEPENDENT shall mean the spouse/child who survives upon the death of the member.

SURVIVING SPOUSE shall mean the husband or wife, as provided by Arizona law, of a current or former elected official, employee, or retiree, who survives upon the death of his/her spouse.

TIMELY FILING shall mean within one year after the date a service is rendered.

VARIABLE HOUR EMPLOYEE shall mean an individual employed by the State, if based on the facts and circumstances at the employee’s start date, for whom the State cannot determine whether the employee is reasonably expected to be employed an average of at least 30 hours per week, including any paid leave, over the applicable 12-month measurement period because the employee’s hours are variable or otherwise uncertain.